Proposition 204 Questionnaire

Please complete the following information regarding your practice and return it to MIHS-HP Provider Services. We will update your practice profile with this information. Please mail or fax to the address below:

MIHS-HP
Provider Services
2502 E University
Phoenix AZ 85304
FAX 602 344 8911

Physicians Name_____

Physician's Specialty_____

Physicians Address_____

Physicians Telephone Number_____

Physicians FAX Number_____

Practitioner Type	Yes	No	Employee's Name	Comments
1. Registered Nurse				
2. Physician Assistant				
3. Nurse Practitioner				
4. Nurse Midwife				
5. Radiological Technician				
6. Laboratory Technician or phlebotomist				
7. Physical Therapist				
8. Chiropractor				
9. Medical Assistant				
10. EKG Technician				
11. Other				
12. Languages spoken in the office other than English. Please name languages and who speaks them as well as their function in your practice in the comment section.				
13. My practice can manage the medical Needs of SMI patients				
14. My practice routinely manages the medical needs of SMI patients.				
15. My practice could use some guidance managing SMI patients				
16. I have checked the "NO" box as I do not want to manage these patients				

Thank you for your anticipated cooperation in this matter. Please make every effort to respond to us by April 16,2001. Direct any questions to Provider Services at 602-344-8957.

1/23/01